



DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
REGION IX

75 Hawthorne Street
Suite 408
San Francisco, CA 94105

MAR 15 2004

Anthony D. Rodgers, Director
Arizona Health Care Cost Containment System
801 E. Jefferson
Phoenix, AZ 85034

AHCCCS/RECEIVED
DIRECTOR'S OFFICE
01 MAR 19 PM 3:15

Dear Mr. Rodgers:

Enclosed is an approved copy of Arizona State plan amendment (SPA) 03-009, which updates the State plan to reflect the Medicaid managed care requirements in the Balanced Budget Act of 1997. I am approving this SPA with the requested effective date of October 1, 2003. As noted in the "Remarks" section of the enclosed form HCFA-179, this approval includes the pen and ink changes requested by Lynn Dunton in her letter to me dated February 26, 2004.

If you have any questions, please have your staff contact Ronald Reepen at (415) 744-3601.

Sincerely,

Linda Minamoto
Associate Regional Administrator
Division of Medicaid & Children's Health

Enclosure

cc:

Joan Peterson, CMS, CMSO, FCHPG
Elliot Weisman, CMS, CMSO, PCPG (two copies)

LIST OF ATTACHMENTS

<u>No.</u>	<u>Title of Attachments</u>
*1.1-A	Attorney General's Certification
*1.1-B	Waivers under the Intergovernmental Cooperation Act
1.2-A	Organization and Function of State Agency
1.2-B	Organization and Function of Medical Assistance Unit
1.2-C	Professional Medical and Supporting Staff
1.2-D	Description of Staff Making Eligibility Determination
*2.2-A	Groups Covered and Agencies Responsible for Eligibility Determinations
* Supplement 1 -	Reasonable Classifications of Individuals under the Age of 21, 20, 19 and 18
* Supplement 2 -	Definitions of Blindness and Disability (Territories only)
* Supplement 3 -	Method of Determining Cost Effectiveness of Caring for Certain Disabled Children at Home
*2.6-A	Eligibility Conditions and Requirements (<u>States only</u>)
* Supplement 1 -	Income Eligibility Levels – Categorically Needy, Medically Needy and Qualified Medicare Beneficiaries
* Supplement 2 -	Resource Levels – Categorically Needy, Including Groups with Incomes Up to a Percentage of the Federal Poverty Level, Medically Needy, and other Optional Groups
* Supplement 3 -	Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered under Medicaid
* Supplement 4 -	Section 1902(f) Methodologies for Treatment of Income that Differ from those of the SSI Program

*Forms Provided

TN # 03-009
 Supersedes TN # 95-04

Effective Date 10/1/03
 Approval Date MAR 15 2004

<u>No.</u>	<u>Title of Attachment</u>
* Supplement 1 -	Income Eligibility Levels
* Supplement 2 -	Resource Levels
* Supplement 3 -	Reasonable Limits on Amounts for Necessary Medical or Remedial Care Not Covered Under Medicaid
* Supplement 4 -	Methods for Treatment of Income That Differ From Those of the SSI Program
* Supplement 5 -	More Restrictive Methods of Treating Resources Than Those of the SSI Program - Section 1902(f) States Only
* Supplement 5a-	Methods for Treatment of Resources for Individuals With Incomes Related to Federal Poverty Levels
* Supplement 6 -	Standards for Optional State Supplementary Payments
* Supplement 7 -	Income Levels for 1902(f) States - Categorically Needy Who Are Covered Under Requirements More Restrictive Than SSI
* Supplement 8 -	Resource Standards for 1902(f) States - Categorically Needy
* Supplement 8a-	More Liberal Methods of Treating Income Under Section 1902(r)(2) of the Act
* Supplement 8b-	More Liberal Methods of Treating Resources Under Section 1902(r)(2) of the Act

* Forms Provided

TN No. 03-009
Supersedes
TN No. 94-01

Approval Date MAR 15 2004 Effective Date 10/1/03

Revision: HCFA-AT-80-38 (BPP)
May 22, 1980

State: Arizona

Citation
42 CFR
431.12(b)
AT-78-90

1.4 State Medical Care Advisory Committee

There is an advisory committee to the Medicaid agency director on health and medical care services established in accordance with and meeting all the requirements of 42 CFR 431.12.

42 CFR
438.104

X The State enrolls recipients in MCO, PIHP, PAHP, and/or PCCM programs. The State assures that it complies with 42 CFR 438.104(c) to consult with the Medical Care Advisory Committee in the review of marketing materials. *

*Members are enrolled with MCOs and receive most behavioral health services through the PIHPs

TN # 03-009
Supersedes TN # 95-15

Effective Date 10/1/03
Approval Date MAR 15 2004

Revision: HCFA-PM- (MB)

State/Territory: ArizonaCitation

42 CFR

435.914

1902(a)(34)

of the Act

2.1(b) (1)

Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.

1902(e)(8) and

1905(a) of the

Act

(2)

For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i) of the Act, coverage is available for services furnished after the end of the month which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.

1902(a)(47)

(3)

Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for Determination of eligibility for this group.

TN # 03-009Supersedes TN # 01-015Effective Date 10/1/03Approval Date MAR 15 2004

Revision: HCFA-PM-91-
1991

(BPD)

OMB No.: 0938-

State: Arizona

Citation 3.1(a)(9) Amount, Duration, and Scope of Services: EPSDT
Services (continued)

42 CFR 441.60 The Medicaid agency has in effect agreements with continuing care providers. Described below are the methods employed to assure the providers' compliance with their agreements.*

42 CFR 440.240 (a)(10) Comparability of Services
and 440.250

1902(a) and 1902
(a)(10), 1902(a)(52),
1903(v), 1915(g),
1925(b)(4), and 1932
of the Act Except for those items or services for which sections
1902(a), 1902(a)(10), 1903(v), 1915, 1925, and 1932 of the
Act, 42 CFR 440.250, and section 245A of the
Immigration and Nationality Act, permit exceptions:

- (i) Services made available to the categorically needy are equal in amount, duration, and scope for each categorically needy person.
- (ii) The amount, duration, and scope of services made available to the categorically needy are equal to or greater than those made available to the medically needy.
- (iii) Services made available to the medically needy are equal in amount, duration, and scope for each person in a medically needy coverage group.
- (iv) Additional coverage for pregnancy-related service and services for conditions that may complicate the pregnancy are equal for categorically and medically needy.

* Describe here.

The continuing care provider submits monthly encounter data reflecting the number of examinations completed, the number of examinations where a referable condition was identified, and the number of follow-up treatment encounters. Medicaid staff make periodic on-site reviews to monitor the provider's record of case management.

Contracts with MCO's specify the compliance requirements for continuing care providers

TN # 03-009
Supersedes TN # 92-25

Effective Date 10/1/03
Approval Date MAR 15 2004

New: HCFA-PM-99-3
JUNE 1999

State: Arizona

Citation

42 CFR 431.51
AT 78-90
46 FR 48524
48 FR 23212
1902(a)(23)
P.L. 100-93
(section 8(f))
P.L. 100-203
(Section 4113)

4.10 Free Choice of Providers

- (a) Except as provided in paragraph (b), the Medicaid agency assures that an individual eligible under the plan may obtain Medicaid services from any institution, agency, pharmacy person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.
- (b) Paragraph (a) does not apply to services furnished to an individual --
- (1) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph (c), or
 - (2) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph (c), or
 - (3) By an individual or entity **excluded** from participation in accordance with section 1902(p) of the Act,
 - (4) By individuals or entities who have **been** convicted of a felony under Federal or State law and for which the State determines that the offense is inconsistent with the best interests of the individual eligible to obtain Medicaid services, or
 - (5) **Under an exception** allowed under 42 CFR 438.50 or 42 CFR **440.168**, subject to the limitations in paragraph (c).
- (c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in section 1905(t), 1915(a), 1915(b)(1), or 1932(a); or managed care organization, **prepaid inpatient** health plan, a prepaid ambulatory health plan, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive emergency services or services under section 1905 (a)(4)(c).

Section 1902(a)(23)
Of the Social
Security Act
P.L. 105-33

Section 1932(a)(1)
Section 1905(t)

TN # 03-009 Effective Date 10/1/03
Supersedes TN # 99-05 Approval Date MAR 15 2004

Revision: HCFA-PM-91-9
October 1991

(MB)

OMB No.:

State/Territory: Arizona

Citation

1902 (a)(58)

1902(w)

4.13 (e)

For each provider receiving funds under the plan, all the requirements for advance directives of section 1902(w) are met:

- (1) Hospitals, nursing facilities, providers of home health care or personal care services, hospice programs, **managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans (unless the PAHP excludes providers in 42 CFR 489.102),** and health insuring organizations are required to do the following:
 - (a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.
 - (b) Provide written information to all adult individuals on their policies concerning implementation of such rights;
 - (c) Document in the individual's medical records whether or not the individual has executed an advance directive;
 - (d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;
 - (e) Ensure compliance with requirements of State Law (whether

TN # 03-009Supersedes TN # 91-26Effective Date 10/1/03Approval Date MAR 15 2004

Revision: HCFA-PM-91-9
October 1991

(MB)

OMB No.:

State/Territory: Arizona

statutory or recognized by the courts) concerning advance directives; and

- (f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.
- (2) Providers will furnish the written information described in paragraph (1)(a) to all adult individuals at the time specified below:
 - (a) Hospitals at the time an individual is admitted as an inpatient.
 - (b) Nursing facilities when the individual is admitted as a resident.
 - (c) Providers of home health care or personal care services before the individual comes under the care of the provider;
 - (d) Hospice program at the time of initial receipt of hospice care by the individual from the program; and
 - (e) Managed care organizations, health insuring organizations, prepaid inpatient health plans, and prepaid ambulatory health plans(as applicable) at the time of enrollment of the individual with the organization.
- (3) Attachment 4.34A describes law of the State (whether statutory or as **Recognized** by the courts of the **State**) concerning advance directives.

Not applicable. No State law
Or court decision exist regarding
advance directives.

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Supersedes TN # 91-26

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Revision: HCFA-PM-91-10 (MB)
DECEMBER 1991

State/Territory: Arizona

Citation 4.14 Utilization/Quality Control

42 CFR 431.60 (a) A Statewide program of surveillance and
42 CFR 456.2 utilization control has been implemented that
50 FR 15312 safeguards against unnecessary or inappropriate
1902(a)(30)(C) and use of Medicaid services available under this
1902(d) of the plan and against excess payments, and that
Act, P.L. 99-509 assesses the quality of services. The
(Section 9431) requirements of 42 CFR Part 456 are met:

_____ Directly

_____ By undertaking medical and utilization review
requirements through a contract with a Utilization and Quality
Control Peer Review Organization (PRO) designated under
42 CFR Part 462. The contract with the PRO —

- (1) Meets the requirements of §434.6(a):
- (2) Includes a monitoring and evaluation plan to ensure satisfactory performance;
- (3) Identifies the ~~services and providers subject to~~ PRO review;
- (4) Ensures that PRO review activities are not inconsistent with the PRO review of Medicare services; and
- (5) ~~includes~~ a description of the extent to which PRO determinations are considered conclusive for payment purposes.

[932(c)(2)
and 1902(d) of the
ACT, P.L. 99-509
(section 9431)

X

A qualified External Quality Review Organization performs an annual External Quality Review that meets the requirements of 42 CFR 438 Subpart E of each managed care organization, prepaid inpatient health plan, and health insuring organization under contract, except where exempted by the regulation

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Effective Date 10/1/03
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Revision: HCFA-PM-91-10 (MB)
December 1991

State/Territory: Arizona

Citation 4.14 Utilization/Quality Control (Continued)

42 CFR 438.356(e)

For each contract, the State must follow an open, competitive procurement process that is in accordance with State law and regulations and consistent with 45 CFR part 74 as it applies to State procurement of Medicaid services.

42 CFR 438.354

42 CFR 438.356(b) and (d)

The State must ensure that an External Quality Review Organization and its subcontractors performing the External Quality Review or External Quality Review-related activities meets the competence and independence requirements.

____ Not applicable.

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Effective Date 10/1/03
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Revision: HCFA-AT-91-4(BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Arizona

Citation 4.18 Recipient Cost Sharing and Similar Charges

42 CFR 447.51
through 447.58

- (a) Unless a waiver under 42 CFR 431.55(g) applies, deductibles, coinsurance rates, and copayments do not exceed the maximum allowable charges under 42 CFR 447.54.

1916(a) and (b)
of the Act

- (b) Except as specified in items 4.18(b)(4), (5), and (6) below, with respect to individuals covered as categorically needy or as qualified Medicare beneficiaries (as defined in section 1905(p)(1) of the Act) under the plan:

(1) No enrollment fee, premium, or similar charge is imposed under the plan.

(2) No deductible, coinsurance, copayment, or similar charge is imposed under the plan for the following:

- (i) Services to individuals under age 18, or under--

☐ Age 19

☐ Age 20

☐ Age 21

Reasonable categories of individuals who are age 18 or older, but under age 21, to whom charges apply are listed below, if applicable.

- (ii) Services to pregnant women related to the pregnancy or any other medical condition that may complicate the pregnancy.

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Revision: HCFA-PM-91-4 (BPD)
AUGUST 1991

OMB No.: 0938-

State/Territory: Arizona

Citation 4.18(b)(2) (Continued)

42 CFR 447.51
through
447.58

(iii) All services furnished to pregnant women.
women.

☐ Not applicable. Charges apply for services to pregnant women unrelated to the pregnancy.

(iv) Services furnished to any individual who is an inpatient in a hospital, long-term care facility, or other medical institution, if the individual is required, as a condition of receiving services in the institution to spend for medical care costs all but a minimal amount of his or her income required for personal needs.

(v) Emergency services if the services meet the requirements in 42 CFR 447.53(b)(4).

(vi) Family planning services and supplies furnished to individuals of childbearing age.

(vii) Services furnished by a managed care organization, health insuring organization, prepaid inpatient health plan, or prepaid ambulatory health plan in which the individual is enrolled, unless they meet the requirements of 42 CFR 447.60.

42 CFR 438.108
42 CFR 447.60

☒ Managed care enrollees are charged deductibles, coinsurance rates, and copayments in an amount equal to the State Plan service cost-sharing.

☐ Managed care enrollees are not charged deductibles, coinsurance rates, and copayments.

1916 of the Act,
P.L. 99-272,
(Section 9505)

(viii) Services furnished to an individual receiving hospice care, as defined in section 1905(o) of the Act.

TN # 03-009
Supersedes TN # 92-25

Effective Date 10/1/03
Approval Date MAR 15 2004

Revision: HCFA-AT-84-2 (BERC)
01-84

State/Territory: Arizona

Citation4.23 Use of Contracts

42 CFR 434.4
48 FR 54013

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 434. All contracts meet the requirements of 42 CFR Part 434.

Not applicable. The State has no such contracts.

42 CFR Part 438

The Medicaid agency has contracts of the type(s) listed in 42 CFR Part 438. All contracts meet the requirements of 42 CFR Part 438. Risk contracts are procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):

 X

a Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2

 X

a Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2

a Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.

Not applicable.

TN # 03-009

Effective Date 10/1/03

Supersedes TN # 84-3

Approval Date MAR 15 2004

New: HCFA-PM-99-3
JUNE 1999

State: Arizona

Citation

1902(a)(4)(C) of the
Social Security Act
P.L. 105-33

4.29 Conflict of Interest Provisions

The Medicaid agency meets the requirements of Section 1902(a)(4)(C) of the Act concerning the Prohibition against acts, with respect to any activity Under the plan, that is prohibited by section 207 or 208 of title 18, United States Code.

1902(a)(4)(D) of the
Social Security Act
P.L. 105-33
1932(d)(3)
42 CFR 438.58

The Medicaid agency meets the requirements of 1902(a)(4)(D) of the Act concerning the safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

TN # 03-009
Supersedes TN # 99-05

Effective Date 10/1/03
Approval Date MAR 15 2004

Revision: HCFA-AT-87-14 (BERC)
OCTOBER 1987

OMB No.: 0938-0193

State/Territory: Arizona

Citation

(b) The Medicaid agency meets the requirements of –

1902(p) of the Act

(1) Section 1902(p) of the Act by excluding from participation—

(A) At the State's discretion, any individual or entity for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII in accordance with sections 1128, 1128A, or 1866(b)(2).

42 CFR 438.808

(B) An MCO (as defined in section 1903(m) of the Act), or an entity furnishing services under a waiver approved under section 1915(b)(1) of the Act, that –

(i) Could be excluded under section 1128(b)(8) relating to owners and managing employees who have been convicted of certain crimes or received other sanctions, or

(ii) Has, directly or indirectly, a substantial contractual relationship (as defined by the Secretary) with an individual or entity that is described in section 1128(b)(8)(B) of the Act.

1932(d)(1)

42 CFR 438.610

(2) An MCO, PIHP, PAHP, or PCCM may not have prohibited affiliations with individuals (as defined in 42 CFR 438.610(b)) suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. If the State finds that an MCO, PCCM, PIHP, or PAHP is not in compliance the State will comply with the requirements of 42 CFR 438.610(c)

TN # 03-009
Supersedes TN # 88-1

Effective Date 10/1/03
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State: Arizona

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than the Medically Needy
(Continued)

42 CFR 435.212 &
1902(e)(2) of the
Act, P.L. 99-272
(section 9517) P.L.

- [] 3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

☐ The State elects not to guarantee eligibility.

☒ The State elects to guarantee eligibility. The minimum enrollment period is ** months (not to exceed six).

The State measures the minimum enrollment period from:

- [] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.
- [X] The date beginning the initial period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.
- [] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

** The single period of guaranteed eligibility is five months plus the remaining days of the first month that the member is enrolled.

TN # 03-009
Supersedes TN # 98-11

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State: _____, Arizona

Agency*	Citation(s)	Groups Covered
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B. Optional Groups Other Than Medically Needy
(continued)

1932(a)(4) of
Act

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56.

This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

X Disenrollment rights are restricted for a period of 12 months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

No restrictions upon disenrollment rights.

1903(m)(2)(H),
1902(a)(52) of
the Act
P.L. 101-508
42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with a

MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

X The agency elects to reenroll the above individuals who are eligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

* Agency that determines eligibility for coverage.

TN # 03-009
Supersedes TN # 93-15

Effective Date 10/1/03
Approval Date MAR 15 2004

State: Arizona

Citation

Sanctions for MCOs and PCCMs

1932(e)
42 CFR 438.726

- (a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:

AHCCCS monitors MCO/PIHP performance by setting contract requirements and reviewing deliverables, onsite Operational and Financial Reviews, and complaint tracking.

- (b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

The state may impose an order of temporary management if there is continued documented egregious behavior, substantial risk to enrollees' health due to non-compliance of the Contractor, or to ensure the health of enrollees while the Contractor corrects the non-compliance, reorganizes, or the contract is terminated.

The state will impose an order of temporary management if a Contractor has repeatedly failed to meet substantive requirements.

- (c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

TN # 03-009
Supersedes TN # 92-21

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